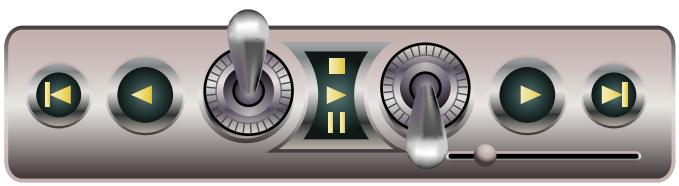
Flight Surgeon Refresher Course

Section 5: Aeromedical Fitness

Flight Duty Medical Exam (FSRC503)



FLIGHT DUTY MEDICAL EXAM

Introduction

Conducting the “Flight Physical” or Flight Duty Medical Exam (FDME) for aviation personnel is one of the most important missions for flight surgeons. Flight surgeons must know the administrative components of the FDME, how to conduct all of the tests and how to process the FDME after completion.

The material found in this lesson is reproduced directly from the ATB: Administrative Guide. Take the time to learn it now. Please refer to the latest version of APL/ATBs for the most recent version.

Objectives:

a. Perform complete and accurate flight physicals (FDMEs and FDHS).

b. Identify the proponent for aeromedical policy in the US Army

c. Describe the four classes of aeromedical military standards

d. Describe the requirements for the FDME and FDHS.

e. Define birth month window and explain the purpose of birth month realignment

f. Define the criteria to issue an FDME extension using the DA Form 4186.

g. Complete the DD 2807, DD 2808, DA 4497 Physical Exam Forms

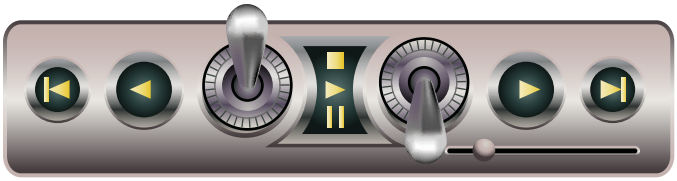
h. Demonstrate or explain how to properly administer these FDME tests: Valsalva, Reading Aloud Test, Anthropometrics

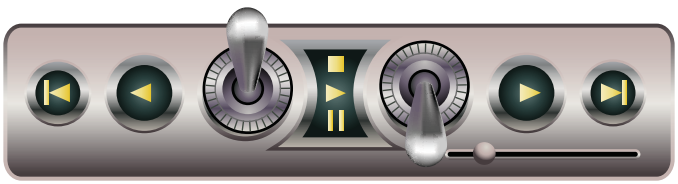
i. Identify unsatisfactory Aeronautical Adaptability traits

j. Describe the review and disposition process

k. Describe the flight surgeon’s responsibilities regarding routing and tracking of FDMEs

l. Identify FDME requirements while deployed





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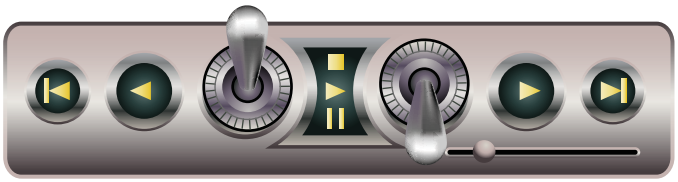


STATEMENT OF PURPOSE

This guide is intended to provide the flight surgeon and his office staff all the tools necessary for accurately completing flight duty medical exams (FDME) and aeromedical summaries (AMS). The required Aeromedical Policy letters and aeromedical technical bulletins (ATB) are available on the USAAMA website: http://usasam.amedd.army.mil/_AAMA/policyLetter.htm.

Additionally, you will find convenient flow sheets designed to ensure that FDMEs are performed correctly and completely thereby minimizing returns for errors. This is a living document and gets updated frequently. You should check the USAAMA website periodically and download the latest version: http://usasam.amedd.army.mil/AAMA.

In addition to guaranteeing a complete FDME, the flow sheets will ensure:

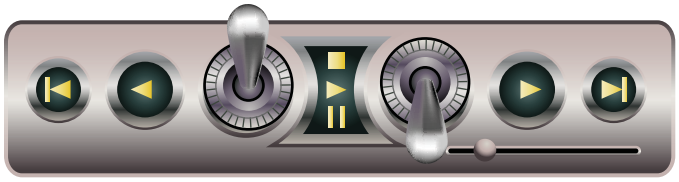
1. That other regulatory and preventive health requirements are adhered to (annual pap smears for women, mammogram, retirement physical requirements, etc.).
2. Important readiness issues are addressed (HIV, dental, eyeglass prescriptions).

A summary sheet of aeromedical standards is provided. This table should be utilized whenever you or your staff are reviewing FDMEs prior to electronically submitting or mailing them to Ft. Rucker. These sheets along with electronic standards checking with the AERO (Aeromedical Electronic Resource Office) will help ensure that all required entries are made and to standard.

There are “special tests” that you probably never heard of prior to becoming a flight surgeon and that are often performed poorly in the field. These are the reading aloud test, anthropometrics, cycloplegic refraction, and stereopsis among others. Each test is addressed in an aeromedical technical bulletin available via the USAAMA website.

In order to help you complete high quality AMSs, there is a section covering the waiver process. Included are templates for both the complete AMS and the abbreviated AMS. This is followed by a brief discussion of the Aeromedical Consultation Service and the waiver authorities. This will help explain the disposition of AMSs / waiver requests.

Please address any comments or questions about this guide or USAAMA policy via the help desk. Links to the help desk can be found on the USAAMA web page, listed above, or on the AERO site. Your feedback is key to system improvement.



The Army Flight Physical

Definition and Responsibility for Flying Duty Medical Examination (FDME)

The FDME is a periodic screening medical examination performed for occupational and preventive medicine purposes. The FDME is used as a starting point for the careful evaluation and treatment of aircrew members. It promotes and preserves the fitness, deployability, and safety of aviation personnel.

The FDHS is the interim health screening tool done between comprehensive FDMEs. The goal is to ensure maintenance of aircrew health and fitness for aviation duty and serve as an opportunity for health promotion.

The aircrew member is responsible for maintaining a current medical certification—DA Form 4186, Medical Recommendation for Flying Duty. In order to have a current DA Form 4186, the aircrew member MUST maintain a current and qualified FDME. The following Army regulations and publications address the importance of the FDME and places the responsibility squarely on the aircrew member.

- AR 600-105 is applicable to rated aircrew (pilots and flight surgeons) and stipulates that Army officers who enter aviation service must continually maintain medical and professional standards. Failure to maintain medical certification is reason to convene a Flying Evaluation Board (FEB). All aviators regardless of component or whether or not assigned to operational flying duties must maintain certification for flying duty through timely completion of the FDME.
- AR 600-106 covers non-rated aircrew (flight medics, aeromedical psychologists, dentists, optometrists, flight engineers, crew chiefs, stewards, et al) and has similar stipulations.
- FM 1-300 covers flight operations procedures and mandates that individuals who do not have a current flight physical or flight physical extension will be suspended from flying status until medical clearance is given.

Proponent for Aeromedical Policy and Standards

US Army Aeromedical Activity (USAAMA): USAAMA is located at Ft. Rucker and is responsible for:

- Writing, implementing and interpreting aeromedical policy,
- Review and disposition of class 1, 2 and 4 flight physicals,
- Final aeromedical recommendation regarding waiver recommendations in cases of disqualified aircrew,
- Maintaining the Aviation Epidemiology Data Registry (AEDR).

US Army Aeromedical Proponency Directorate (USAAPD). Also at Ft. Rucker, the Director is responsible for overall oversight of the US Army Aviation Medicine Program and Policy review.

Types of FDMEs/Screenings—the Basics

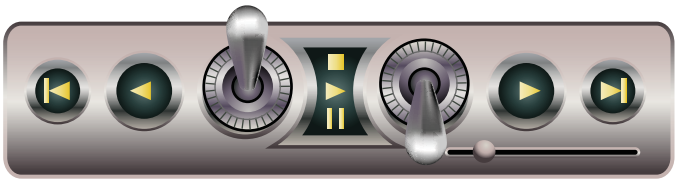
There are two broad categories of FDME. They are:

Initial FDME. Performed for accession purposes. They are valid for up to 18 months.

Comprehensive FDME. Performed on aircrew once already trained. This is a retention-type of FDME and is performed for re-certification purposes every 5 years between the ages 20 and 50 and then annually thereafter. The five year period is based on the year of the initial FDME or the date of the last comprehensive FDME. It is generally valid for 12 months and is synchronized with the aircrew member's birth month.

There is one category of health screen:

FDHS. Performed on aircrew once already trained. This is a retention-type of health screen and is performed for re-certification purposes in the years that a comprehensive FDME is not required. It is generally valid for 12 months and is synchronized with the aircrew member's birth month.



Aeromedical Standards Class or FDME "Class"

FDMEs are typically referred to according to "class" or more accurately, by the aeromedical standards classification that apply to an aircrew member. The type of duties performed by the aircrew member as well as whether he is an applicant or a trained crewmember determines the applicable standards.

These aeromedical standards are analogous to the accession and retention standards found in chapters 2, 3, and 4 of AR 40-501, Standards of Medical Fitness, applicable to all Army soldiers. Chapter 4 of this regulation addresses aeromedical standards. The following is a brief description of the classes of aeromedical standards and examples of which types of aircrew comprise that class.

CLASS 1W/1A

Initial entrance (accession) physical examination standards for warrant officer candidates (1W) and commissioned officers (1A) that want to be pilots. Physical examinations performed for this purpose are initial FDMEs and are valid for up to 18 months from date of examination.

CLASS 2

Includes all rated aviators (pilots and flight surgeons) as well as aeromedical physician assistants.

Class 2 can be further broken down into three categories:

1. Initial Class 2: Accession standards for flight surgeons (FS) and aeromedical physician assistants (APA). Also applies to previously rated (trained) pilots, FS and APA who for some reason have had a break in aviation service of greater than five years and are now returning to aviation service. Valid for up to 18 months.
2. Comprehensive Class 2: FDME standards applied to rated (trained) pilots and flight surgeons. Also applies to aeromedical physician assistants (though they are technically "non-rated") and flight students once in flight training (though not yet rated). A Flight Student's status changes from class 1 to class 2 at the start of the initial flight training course leading to award of an aeronautical rating and in that course of instruction once training is started at aircraft controls, per AR 600-105, Aviation Service of Rated Army Officers, paragraph 3-3 (a & b), December, 1994, and AR 40-501, Standards of Medical Fitness, paragraph 4-2 (b)(1), March, 2002. A comprehensive FDME is generally valid for a period of 12 months; exceptions will be discussed in subsequent sections.
3. Interim Class 2: FDHS standards applied to rated (trained) pilots and flight surgeons and additionally to aeromedical physician assistants. The FDHS is done in the years that a comprehensive FDME is not required. The annual FDHS is generally valid for a period of 12 months.

CLASS 3

Encompasses all other crewmembers and non-crewmembers and other personnel required by competent authority to fly in Army aircraft. This includes: flight medics, aeromedical psychologists, dentists and optometrists, flight engineers, crew chiefs, stewards, et al. NOTE: Currently, Unmanned Aerial Vehicle (UAV) operators are required to meet class 3 standards.

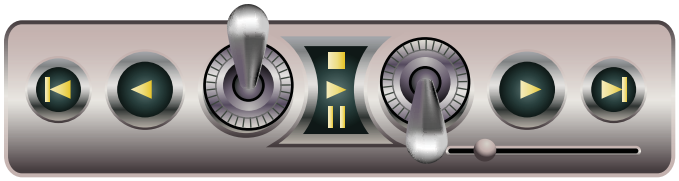
Class 3 can be further broken down into three categories as well:

1. Initial Class 3: Accession standards for non-rated aircrew. Valid for up to 18 months.
2. Comprehensive Class 3: Retention standards for non-rated aircrew. An annual FDME is generally valid for a period of 12 months; exceptions will be discussed in subsequent sections.
3. Interim Class 3: Retention standards for non-rated aircrew. An annual FDHS is generally valid for a period of 12 months, and is done in the years that a comprehensive FDME is not required.

CLASS 4—MILITARY

These standards are applied to air traffic controllers (ATC).

1. Initial Class 4: Accession standards for all ATC. Valid for up to 18 months.
2. Annual Class 4: Retention standards for all ATC. An comprehensive FDME is generally valid for a period of 12 months; exceptions will be discussed in subsequent sections.



3. Interim Class 4: Retention standards for all ATC. An comprehensive FDHS is generally valid for a period of 12 months, and is done in the years that a comprehensive FDME is not required.

CLASS 4—CIVILIAN

- Current Operating Manual for Qualification Standards for General Schedule Positions Office of Personnel Management (OPM) standards address both application and retention for ATCs. (found at http://www.opm.gov/qualifications/index.htm). These standards do not provide any specific means to apply those standards nor do they outline any process to waiver medical conditions or continued medical treatment for continued safe execution of ATC duties.
- The Class 4 FDME/FDHS requirements, as outlined in paragraph 4-33 (c) of AR 40-501, will be used as the basis for conducting annual FDME/FDHSs for DAC and civilian contract ATC personnel. However, only OPM standards/ requirements will apply for these individuals. Refer to the aeromedical technical bulletin on the conduct of these examinations.
- Aeromedical Summaries and waiver requests for those conditions not meeting current application or retention standards for DAC/civilian ATCs will be processed per current USAAMA policy. Review of cases involving DAC or civilian contract ATCs will include consideration of the likelihood of deployment to austere environments or stationing away from regular medical care.

What are FDME requirements when on deployment?

FDME requirement can only be suspended by the Office of the Surgeon General (OTSG)

Do as much as practical and attach a memo explaining the extenuating circumstances

Complete the FDME upon return from the deployment

Realign with birth month if necessary

Types of FDME—the Bigger Picture

Previously we broke down FDMEs into Initial and Comprehensive. In essence, the initial FDME is a comprehensive FDME plus a few extra items. In the recent past comprehensive FDMEs were done every 3 years, but review and analysis suggested this was not necessary to ensure aeromedical fitness for flying duty. Comprehensive FDMEs will be completed every 5 years between the ages of 20 and 50 and then annually thereafter. The five year period is based on the year of the initial FDME or the date of the last comprehensive FDME. In between comprehensive FDMEs, we obtain an interim (or abbreviated) Flying Duty Health Screen. The checklist on pages 12-13 provides a simple “go-by” to determine what is required on an FDME- initial or comprehensive and the requirements for the FDHS-interim. This same information is presented in tabular form on pages 14-17.

The initial and comprehensive FDMEs are performed on DD Forms 2807-1 and 2808. They are performed in much the same way as any Army quadrennial physical exam. The interim (or abbreviated) Flying Duty Health Screen is performed on the DA Form 4497R but can also be done using the electronic submission on DD Forms 2807-1 and 2808. DA Form 4497R is a simple one-page document that is not intended to be a full history and physical. It is simply a health screening to assess some of the more relevant health indicators in our aircrew, and allow each aircrew member an annual visit with their health care provider.

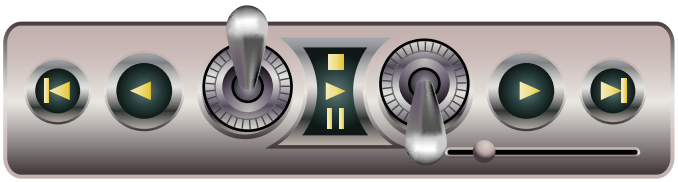
Initial FDME

The contents are essentially the same for all initial FDMEs for class 2, 3, and 4. The only difference here is that a class 2 initial requires anthropometric measurements and a class 3 and 4 do not. For Class 2F , anthropometric measurements are not required but are highly encouraged. Cycloplegic refraction is the only requirement needed to make an initial class 2 into a class 1 FDME.

Comprehensive FDME

The contents are the same for all comprehensive FDMEs regardless of class (2, 3, or 4). The FDME captures the same information on all aircrew under similar circumstances.

- Performed every five years between the ages of 20 and 50 and then annually thereafter. The five year period will be based on the year of the initial FDME or the date of the last comprehensive FDME. For example, if an initial applicant



has his initial FDME done at age 23, his next comprehensive FDME would be required at age 28. Both the AERO and AKO will be used to assist in tracking when the comprehensive FDME is required.

- Additionally, a comprehensive FDME is required when requesting return to aviation service after medical termination, following aircraft accidents, and for retirement purposes.
- Recall to aviation service requires a comprehensive FDME, unless the individual is returning to service within 5 years of their last qualified comprehensive FDME. In this case only an interim FDHS is required.

Interim or Abbreviated (Short) FDME/Flying Duty Health Screen

Performed during the interim years when comprehensive or initial exams are not required. For example, a crewmember will receive a comprehensive FDME for his 30th birthday and an interim FDHS on his 29th and 31st birthdays. All FDHSs are the same regardless of class (2, 3, or 4).

Birth Month Window

Comprehensive FDMEs are synchronized with the birth month. Army regulations allow for a generous birth month window that encompasses the "three-month period preceding the end of the birth month". In other words, it includes the birth month plus the two previous months. All exams taken within this period are considered to have been taken within the birth month and will be good to the end of the birth month of the following year.

Example: A soldier born in July may begin his FDME/FDHS 3 months prior to 31 July. That means he can start the process on 1 May and he must complete it no later than 31 July. By the same token, if he completes it in May it will still be valid until the last day of July in the following year. All exams taken within this period are considered to have been taken within the birth month.

Birth Month Realignment

Just as the type of comprehensive FDME (comprehensive or interim) is aligned with a crewmember's age, his FDME is aligned with his birth month. The FDME is completed in conjunction with his birth month (in the three-month window) and it is valid until the last day of the birth month the following year.

Sometimes, a crewmember may get a FDME outside of his birth month window. In fact, the initial FDME is done without regard to the birth month—it is performed when it is needed for application to aviation service. Another example is deployment that can impact and upset the birth month cycle. Other examples include FDMEs performed for permanent medical suspension, FEB, or in conjunction with an accident investigation—all of these can disrupt the birth month cycle.

In these cases, we strive to realign the crewmember with his birth month AND avoid performing excessively frequent FDMEs. In these cases, Table 1 on page 6 may be used. This table provides you with the maximum period of validity for a FDME in order to realign the crewmember with his birth month. To avoid confusion with the flight records section, the FS MUST clearly document the birth month realignment in the remarks block of the DA Form 4186, "upslip". Otherwise, the flight records sections will be asking questions as to why the FDME was valid for longer than 12 months.

Example: A crewmember has a July birth month, but he just had an FDME post-mishap in February, the flight surgeon can extend that FDME until July of the following year instead of performing another FDME in five months. In this example, the FDME will have a period of validity of 17 months (remember, the maximum allowed is 18 months). NOTE: This has nothing to do with extensions beyond the end of the birth month. That topic follows next. The FDME must be completed prior to the end of the birth month in which it is due.

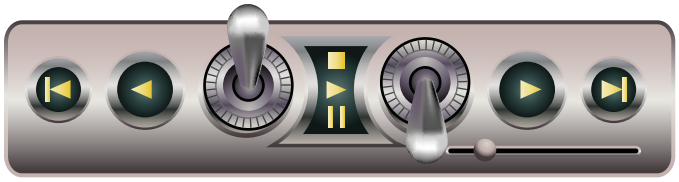


Table 1: Birth-month Realignment Table (Number of months for which an FDME is valid)

Birth Month	Month in which last FDME was given											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

Note: Read down the left column to the examinee's birth month; read across to month of last FDME; intersection number is the maximum validity period.

Extensions

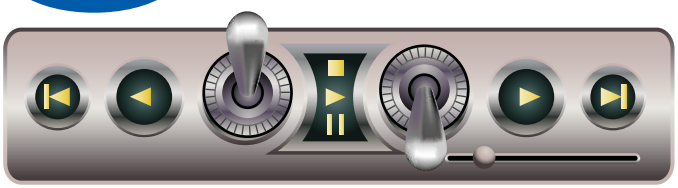
In the eventuality that a FDME or FDHS cannot be completed prior to the end of the birth month, the flight surgeon may grant a one calendar month extension. For example, our soldier born in July fails to complete his FDME/FDHS before 31 July. The flight surgeon may grant him an extension and upslip to cover him through 31 August. Back-back extensions or extensions exceeding one calender month cannot be granted. If on 31 August this crewmember still has not initiated his FDME/FDHS, he must be grounded. The only exception to this policy is by special policy directive from the Surgeon General's office.

AFS or APA is authorized to issue a SINGLE one calendar month extension (using the DA 4186) to allow the aircrew member some additional time to complete his Flight Physical.

The extension must be issued prior to the last day of the birth month.

Internal Summary—The Army Flight Physical, Key Points

- The period of validity for all FDMEs is determined by only one thing—if it is an initial physical or a periodic (comprehensive) FDME. Regardless of class (1,2,3 or 4) or type (comprehensive or abbreviated) all initial FDMEs are valid for 18 months and periodic FDMEs are valid for 12 months.
- All FDMEs must be completed within the birth month window.
- All periodic FDMEs are valid until the last day of the birth month in the following year.
- The period of validity of a periodic FDME may be extended up to 18 months in order to realign a crewmember with his birth month.
- An extension for one calendar month beyond the birth month is possible. NO MORE.



Completing the FDME Paperwork

In order to ensure that a FDME is completed properly, it is best to use a checklist during completion of the FDME and during the review process. The next page provides a checklist for all FDMEs. The checklist is intended to aid the aviation medicine clinic staff in completing "PART 1" of the FDME. FDME are commonly broken down into two parts. This is an artificial breakdown and **not** required. It is however employed by most Army clinics. Please be sensitive to the needs of you crewmembers and if necessary, conduct the **entire** FDME on the same day. This is especially true of Abbreviated FDME/Flying Duty Health Screens -- The requirements for the abbreviated FDME can easily be completed in one day and allow for more time with the FS for each aviator. This is an opportunity to address preventive health measures and answer questions for your aircrew.

Part 1

Part 1 of a physical consists of compiling all the information/data that the flight surgeon will need. It covers:

- Personal information
- Past medical history
- Vital signs/Arthropometrics
- Vision testing
- Audiology
- ECG (Only required on initial FDMEs and then annually after age 40 as part of Cardiovascular screening program.)
- Dental
- Pap (Not required on Initial FDMEs)
- Lab

Part 2

Part 2 is the Physician "hands-on" part of the FDME. Ideally, all the data collected in Part 1 is available for review by the flight surgeon when the patient returns for Part 2. This way, once the flight surgeon performs the physical exam, he has a complete packet that is ready for an aeromedical disposition to be made. In addition, this is the time to address preventive health measures and key areas of medical history such as use of dietary supplement/herbals or other over the counter products.

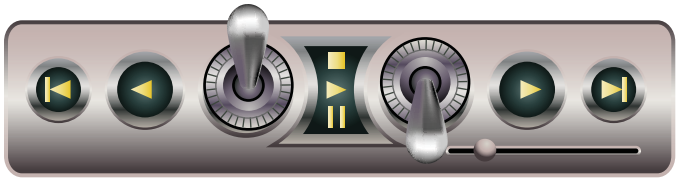
FDME/FDHS Checklist

Notice that the checklist has several features to ensure accuracy and completeness. There is no requirement to use this checklist- it is furnished as an aid for your clinic operations. You are free to develop your own tools, but if you do so, remember to keep it simple.

The "new improved" FDME checklist created by USASAM as a training tool is available on the USASAM web site: http://usasam.amedd.army.mil. It is included at the end of this lesson for your convenience!

Some issues to consider:

- **DOB and "age for this exam" are noted at the very top. This will help you determine:**
  - **Does he require a comprehensive or interim exam?**
  - **Is the patient over 40? (triggers over-40 requirements)**
  - **Remember that when a crewmember reports for his comprehensive FDME, he is usually reporting one or two months prior to his birth month. In determining the type of physical (comprehensive or abbreviated) you must use his age for the upcoming birthday. Example: a crewmember is 38 today but will be 39 next month. Use 39 as the "age for this exam".**
- **Aviation requirements for HIV testing are required with the comprehensive FDME every five years. Remember that for Army Force Protection requirements, HIV testing is required every two years. This should be done but is only required to be reported on the comprehensive FDME.**
- **Good telephone points of contact are noted in order to facilitate contact with the patient.**
- **Notice there are only three types of physical exams regardless of the class.**
  - **Initial**
  - **Comprehensive**
  - **Interim (Abbreviated)**



Note: There are subtle differences between a class 1 initial and a class 3 initial—those differences are annotated in the table. Keep it simple—there are only three types of FDMEs. Select the applicable column and ensure all items in the column are completed.

- **There are two additional sections that are age dependent and may be applicable. If they are, ensure they are completed. These sections are listed immediately following the three main columns. They are required for all types of FDMEs (initial, comprehensive and abbreviated).**
  - **Over 40**
  - **Retirement/Separation**
- **The last section allows the administrative staff to note any additional tests or studies that may be required. The easiest way to determine this is to ask the patient if he has any "waivers". In addition, the aviation medicine clinic staff should review the medical record or check the AERO. If the aircrew member has a waiver, a copy should be kept in the Health Record (HREC).**
- **Additionally, there should be a copy of the Aviation Epidemiology Data Registry (AEDR) printout attached to the last qualified FDME in the HREC or this information is available via a AERO query. The AEDR printout will also mention if any waivers are in effect and if any additional tests or studies are required. If any additional tests, or studies are required, the clinic staff should order them now to ensure the results are back in time for "Part 2". If questions reference any additional requirements exist , the clinic staff should address them to the flight surgeon/APA during "Part 1." Tables 2 and 3 on provide a consolidated list of FDME requirements by type.**

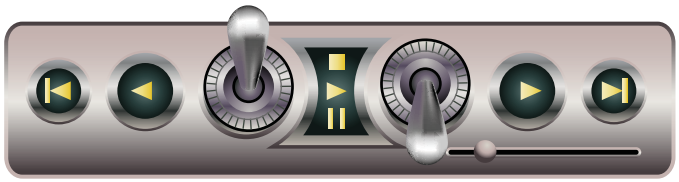
The Required Forms

Initial and Comprehensive FDME: Performed on the same DD 2807 and DD 2808 (dated July 2001) that other military physicals are performed on. When the crewmember shows up for part one of his FDME, he/she should fill out all the demographic data on these forms. All entries (dental, optometry, etc.) should be placed on this form either electronically or manually.

Interim FDME/Flying Duty Health Screen: Performed on DA Form 4497 (March 2002) or entered electronically on the DD Form 2807-1 and 2808. The DA Form 4497-R is a stand-alone form and documents both medical history and physical exam. This form is found via DA Form search at the USAPA website:

http://www.usapa.army.mil/usapa_home.asp

NOTE: Either both the DD 2807-1 and DD 2808, or the DA Form 4497, whichever is submitted to meet requirements, must be reviewed and signed either electronically or manually by the flight surgeon or electronically by the APA. ECGs with abnormal readings may be sent for further review at USAAMA, but those with normal variants only require a code or normal/abnormal entry on the FDME/FDHS.



Home Phone ( )	**DOB:**	**Age for**	***HIV Req.?**	**Date:**
Work Phone ( )		**this exam:**	**YES / NO**	

Class 1/1A and All Initial Class 2, 3 and 4	**Comprehensive FDME** (every 5 years between the ages of 20 and 50 and then annually thereafter-based on date of initial FDME or last comprehensive FDME)	**FDHS**
Vital signs _____ BP, Pulse, Ht, Wt, Anthros (Class 1/1A) only) **Vision**_____ VAs, Phorias by AFVTA, Cover-uncover test (tropias), Cross-cover test (phorias), NPC, IOPs, Color vision, Stereopsis/Depth Perception, Visual fields, Night vision Hx Refraction • Cycloplegic (Class 1/1A only) • Manifest (Eyeglass Rx-All classes if uncorrected <20/20) **Audio** _____ **ECG** _____ **Dental** _____	**Vital signs** _____ BP, Pulse, Ht, Wt **Vision**_____ VAs, Phorias by AFVTA, Stereopsis/Depth Perception, Manifest Refraction / Eyeglass Rx (All classes if uncorrected <20/20) **Audio** _____ **Dental** _____ **Pap & Pelvic** _____	**Vital signs** _____ BP, Pulse, Ht, Wt **Vision** _____ VAs, Stereopsis/Depth Perception Manifest Refraction / Eyeglass Rx (All classes if uncorrected <20/20) **Audio** _____ **ECG** not required unless clinically indicated or required by waiver or age 40 or over **Dental** _____ **Pap & Pelvic** _____
Labs UA w/ microscopic, HCT, HIV, FBS, Sickledex (excluding class 4) , Chol, HDL, Trig, LDL	**Labs** *HIV, UA w/ microscopic, HCT, Chol, HDL, LDL, Trig, FBS	**Labs** None unless clinically indicated or per waiver requirements
Notes: RAT and AA (ARMA) Valsalva Refractive Surgery-see APL Contact Lens Wear- see APL Rectal & guaiac (Rectal by inspection to age 40 and then DRE and stool guaiac required annually)	**Notes:**	**Notes:** "Health Screening" / Directed Physical Exam Dental and Pap/Pelvic are recommended for health promotion but are not required FDHS entries

Age 40 and over (for all classes; initial /comprehensive FDME and FDHS), add:	**Retirement:**
Fasting Blood Sugar CVSP (Cardiac Risk Index calculated by AERO) Rectal and Stool guaiac/Prostate Exam for males PSA (Males- on comprehensive examinations only) Mammogram: 40,42, 44,46,48,50, then yearly (req for all AD females) IOPs EKG	Perform a comprehensive FDME CXR if age 40 or over DD Form 2697 Counseling on Hepatitis C screening **NOTE:** Must be a comprehensive exam

Additional tests, studies and consults:

Last Name	**First**	**MI**	**Rank**	**Provider's Stamp**	**Status**

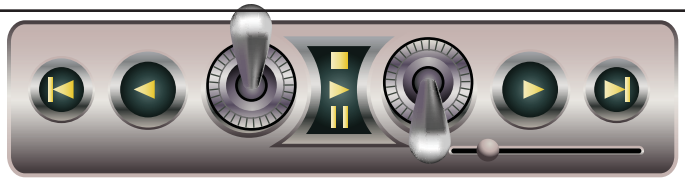


Table 2: Summary of DD Form 2808, Jul 2001 (not included in this lesson-see ATB)

Special Tests—Aviation Unique

The FDME is conducted just like any other physical exam. The procedure is the same. There are a few items that are commonly checked on a FDME that most physicians are unfamiliar with because they are unique to the FDME. Some of these items may be performed somewhat differently between the various military services and the FAA. These tests include:

- **The Valsalva Maneuver-ATB**
- **Reading Aloud Test-ATB**
- **Anthropometrics-ATB**
- **Cycloplegic Refraction-ATB**
- **Binocular Depth Perception-ATB**
- **Aeronautical Adaptability-APL**

Valsalva Maneuver

- Required of all aircrew except ATC on all FDMEs
- Gross evaluation of Eustachian Tube Function

Reading Aloud Test

- A phonetic exercise
- Subjective evaluation
- Try to assess clear, safe, effective communication:
  - **Stutter / stammer**
  - **Learning disability**
  - **Excessively introverted, indecisive, careless**
  - **Marginal English skills**

Aeronautical Adaptability (AA)

It is easier to explain what AA is not than it is to explain what it is. An unsatisfactory AA is not a DSM IV diagnosis. AA covers sociobehavioral factors considered unsuitable for adapting to military aviation, both medical and non-medical. It is behavior that may be caused by underlying, undiagnosed psychiatric disorders not meeting full DSM-IV criteria but it is not limited to this. There is no diagnostic test or battery of questions to determine whether the aviator is AA Sat or Unsat.

Unsat AA is a consensus of opinion endorsed by the Commander, USAAMC, that after thorough investigation involving the unit flight surgeon and aviation chain of command (military) or supervisory chain (civilian), certain behavior or conduct is unadaptable or unsuitable for Army aeronautics. It is covered in AR 40-501, chapter 4-29.

Aeronautical Adaptability

What are unsatisfactory Aeronautical Adaptability traits?

AA is not a psychiatric diagnosis . It covers many sociobehavioral characteristics that may have a negative impact on the safety of flight

Examples of unsatisfactory conditions:

Concealing / lying about medical history

Unhealthy attitude about flying

Undesirable personality traits

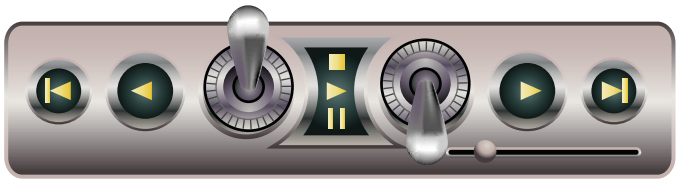
Persistent psychosomatic traits

Antisocial behavior

Unresolved interpersonal problems

"Kitchen sink"— careless and poor motivation

Any other condition for which the local FS or aviation commander requests a consultation with the U.S. Army Aeromedical Consultation Service



Anthropometrics

Anthropometrics are not disqualifying, but serve as useful data for the selection of aircrew for specific air frames. They are measured remarkably different in each of the services, so be familiar with the different procedures required for each service. Following are the methods for recording Anthropometrics for the Army. They are only required for INITIAL FDMEs.

Record in centimeters, to the nearest tenth:

1. Crotch Height (Leg Length)

- The subject must stand completely erect against a wall, heels together, weight evenly distributed, and knees locked.
- The measurement is taken parallel with the wall from the floor to a point where light contact is made with the perineum in the midline.

2. Total Arm Reach

- The subject must stand erect against a wall, arms outstretched at a 90-degree angle and parallel with the wall.
- The elbows must be locked.
- The fingertips of one hand must be in contact with the adjacent wall in the corner of the room.
- The horizontal distance between fingertips is recorded.

3. Sitting Height

- The subject must sit on a hard, flat surface, facing forward, feet flat on the floor, with buttocks, shoulders, and back of head against the wall.
- Using a right angle on the head, the distance between the sitting surface and the top of the head is recorded in centimeters.

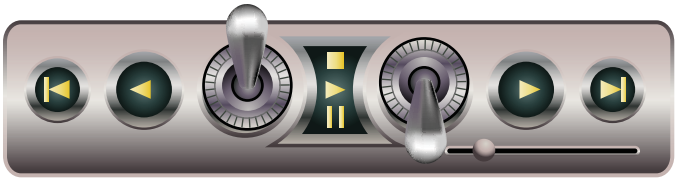


Table 4: Summary of Aeromedical Standards—Vision, Hearing, Labs, Anthros

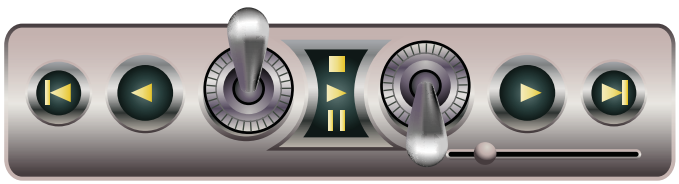
Aeromedical Vision Standards							
Cycloplegic Refraction Standards			**Visual Acuity, DQ if worse than:**		**Phorias, DQ if:**		
Class	[Qualified]		Distant	Near	Eso	Exo	Hyper
1/1A*	Sphere: DQ < -1.50 to +3.00 < DQ Cyl: DQ < -1.0 to +1.0 < DQ		20/50	20/20	>8	>8	>1
2/3/4	NOT REQUIRED		20/400	20/400	>8	>8	>1
Class	**Cover-Uncover Test**	**Cross-Cover Test**	**NPC DQ if:**	**Color Vision DQ if:**			
1 and 2/2F/3/4 Initial	Any detectable movement referred to optometry	Any detectable movement referred to optometry	>100mm	**PIP:** 5 or more errors out of 14 plates **FALANT:** any errors out of 9 presentations or 3 or more errors out of 18 presentations			
2/3/4 Other	Not Req	Not Req	Not Req	Not Req			

All Classes of Aeromedical Standards	
Field of Vision, DQ if:	Any Defects
Depth Perception, DQ if:	>40 seconds of arc at 20 feet: • Any error in blocks B through D of the AFVTA, Titmus II or Optec 2300, or • Any errors in lines 1 through 7 of the 10 Level Randot Circles test
IOP, DQ if:	23 mmHg or greater in either eye or, 4 or more mmHg difference between eyes

Aeromedical Audiology Standards Qualified if Equal or Better than:						
Class	**500Hz**	**1000Hz**	**2000Hz**	**3000Hz**	**4000Hz**	**6000Hz**
1//1A	25 db	25 db	25 db	35 db	45 db	45 (see APL)
2/3/4	25 db	25 db	25 db	35 db	55 db	65 (see APL)

Laboratory Normal Values, All Classes					
HCT/Hb	Male 40% - 52% (14-18 gm/dl)		Female 37% - 47%(12-16 gm/dl)		
UA Dipstick	Gluc Neg	Prot Neg	**UA Micro**	<5 RBC	<5 WBC
Category		*Fasting Blood Sugar*		*2-Hour Post-Prandial*	
Normal		<110		<140	
Impaired Glucose Tolerance		110<FBS<126		140<2HPP<200	
Diabetes Mellitus		>126>105		>200	
Gestational Diabetes Mellitus				>165	

Anthropometric Standards (Class 1/1A and Class 2/2F) Qualified if:	
Total Arm Span, (TAS)	Greater than or equal to 164cm
Crotch Height, (CH)	Greater than or equal to 75cm
Sitting Height, (SH)	Less than or equal to 95cm for career transition to OH58 / TH67 Less than or equal to 102cm for all others



Aeromedical Disposition

The aeromedical disposition is the fitness for duty determination made on an aircrew member by the FS or APA after careful examination and thoughtful application of current aeromedical standards.

Medically Qualified

Whenever a crewmember meets the aeromedical standards set forth in AR 40-501 and the Aeromedical Policy Letters (APLs).

Medically Disqualified (DQ)

Whenever a crewmember does not meet the medical standards set forth in AR 40-501, chapter 4 and the APLs or he is not able to safely perform the duties required of an air crewmember he is said to be medically disqualified from aviation service.

Permanent Disqualification

Imposed when a medical condition that impairs the safe performance of aircrew duties is expected to last longer than 12 months or, the disqualifying condition is specifically listed in AR 40-501, Chap. 4 or in the APLs as aeromedically disqualifying. Examples include diabetes, heart attack, HIV sero-positivity, hypothyroidism or hypertension. These conditions are listed in AR 40-501 as being unfit for aviation service and are thereby disqualifying. Some of these conditions (e.g. hypothyroidism and hypertension) when properly treated will not present a danger to aviation safety and these aircrewmembers can get a waiver. Other conditions such as heart attacks, strokes, or HIV infection will present a persistent danger to aviation safety and the aircrew member will usually not be granted a waiver.

Permanent disqualifying conditions require a waiver in order for the aviator to continue in aviation service. See waiver below.

Temporary Disqualification

Imposed for a disqualifying medical condition not covered in AR 40-501 or the APLs that is expected to last less than 12 months prior to resolution. When the condition resolves, the crewmember is again considered qualified to perform aviation duties. Examples include the common cold, ankle sprain, minor back injuries, simple fractures and uncomplicated pregnancies. If however, the condition fails to resolve within 12 months and it continues to prevent the crewmember from safely performing his duties, the condition will be treated as a permanent disqualification.

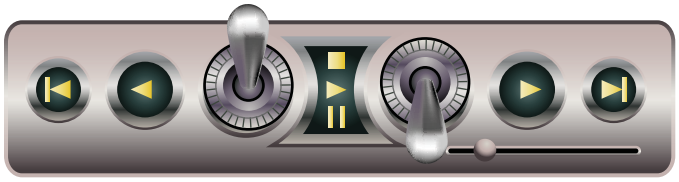
Temporary disqualifications do not require waiver action.

Waivers

A waiver is a document from the waiver authority (e.g. PERSCOM or the NGB among others) that grants continued flight status in spite of a disqualifying defect. This document waives the requirement for the aviator to meet a specific medical standard.

Exception to Policy. It is mostly a matter of semantics, but waivers are not granted for Class 1W or 1A standards. If a Class 1W or 1A applicant does not meet medical standards, he must get an exception to policy prior to entering aviation service. An exception to policy is scrutinized more carefully and is much more difficult to obtain though the process is the same as that for a waiver.

A Flight Student's status changes from class 1 to class 2 at the start of the initial flight training course leading to award of an aeronautical rating and in that course of instruction once training is started at aircraft controls, per AR 600-105, Aviation Service of Rated Army Officers, paragraph 3-3 (a & b), December, 1994, and AR 40-501, Standards of Medical Fitness, paragraph 4-2 (b)(1), March, 2002.



In order for an aircrew member to get a waiver, the flight surgeon performs a thorough medical evaluation of the condition and documents the evaluation in an Aeromedical Summary (AMS). The AMS process is detailed below. The FS submits the AMS along with his recommended aeromedical disposition (waiver recommended versus waiver not recommended) to the Army Aeromedical Activity (AAMA). If a waiver recommendation is ultimately approved, the crewmember may continue on flight status. If the waiver is not approved, the crewmember will be removed from flight status.

Medical Recommendation

The flight surgeon is a special staff officer on the commander's staff. Like other staff officers, the flight surgeon is a subject matter expert who makes recommendations to the commander. The flight surgeon enjoys a position of special trust with the commander and typically, the commander approves the flight surgeon's aeromedical recommendations. Technically, until the commander approves the flight surgeon's recommendations, they are just recommendations and carry little weight.

Approval Authority

The commander is the approval authority. The goal is to determine at what level of the command does this authority reside. When dealing with waiver (or exception to policy) recommendations, this is also known as the waiver authority. A comprehensive list of waiver authorities is listed on page #.

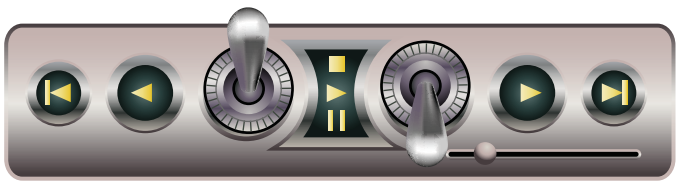
FDME/FDHS Review and Disposition

Class 1, 2, and 4:

All class 1, 2, and 4 FDME/FDHSs are submitted electronically via the AERO or manually to USAAMA at Ft. Rucker for final review and disposition (this includes all initial, comprehensive FDMEs and interim FDHSs). USAAMA will input the FDME/FDHS into the Aeromedical Epidemiology Data Registry and ensure the FDME/FDHS is complete and that all parameters are within Army aeromedical standards. If it is complete and within standards, it will be stamped or coded as "Qualified" and returned to the clinic that originated the FDME/FDHS for inclusion in the health record. If using the AERO, the FDME/FDHS form may be printed and placed in the HREC. The electronic qualification notification may be printed and placed in the HREC as well. If the FDME/FDHS is missing required information or it is has any parameters outside Army aeromedical standards it will be stamped or coded as "disqualified incomplete" or "disqualified" and returned to the clinic that originated the FDME/FDHS. A printout or status report delivered electronically listing missing items will accompany incomplete FDME/FDHSs. Incomplete FDME/FDHSs will be completed and resubmitted to USAAMA. Disqualified FDME/FDHSs are discussed below.

Class 3:

Class 3 FDMEs are not submitted to USAAMA. They are reviewed by the local flight surgeon and filed directly in the crewmember's health record. There is no central review. As the local FS, you serve as the final review and disposition for Class 3 FDMEs. Certain condition (drug and alcohol abuse or depedence) do require AAMA review and any case that you are not comfortable with locally may be sent to AAMA for review.



Waiver Review and Disposition

Waiver Review and Disposition for Classes 2 and 4 and Exceptions to Policy (class 1) is performed centrally at USAAMA in a similar manner to FDMEs.

Once USAAMA performs a central medical review, it forwards its medical recommendation to a centralized waiver authority (e.g. PERSCOM, NGB, etc.). The waiver request is approved / disapproved by the centralized waiver authority and is centrally managed. If granted, the waiver follows the crewmember from duty station to duty station.

In contrast, Class 3 waiver requests are processed locally just as Class 3 FDMEs are processed locally. The FS makes the definitive medical recommendation and the local unit commander is the waiver authority (may grant or deny the waiver). The waiver is a local waiver and must be renewed upon change of station (new unit, new commander, new waiver authority). For specifics, refer to the APL titled: Class 3 Aircrew Members in the Miscellaneous section of the APLs. Note that there are a few conditions (exceptions to the rule) that must be processed through USAAMA for which the local FS and commander do ***not*** have waiver authority.

Summary of Waiver Dispositon:

The first aeromedical disposition is made by the local flight surgeon in all cases. For class 3 aircrew, it is also the only aeromedical review in the vast majority of cases. The local commander is the approval authority. For class 2 and 4 waivers (as well as ALL exceptions to policy-class 1W/1A), the package is forwar

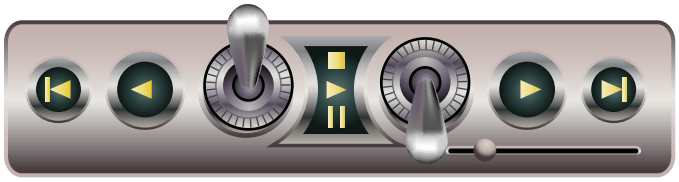
The Waiver Process

This process will be discussed using the central review process employed for Class 1, 2, and 4 aircrew. Remember that Class 3 aircrew waivers are generally processed locally and do not have central review.

The waiver process has been developed to ensure the consistent and proper management of disqualified aviation personnel. This process has been responsible for the safe return of countless aviators to flying duties once effective treatment has been achieved. It also has been responsible for clearly identifying those individuals with medical conditions incompatible with continued safe flying or their continued good health. It allows for consistent health care management of individuals who routinely receive their health care from many different health care providers. With proper utilization of senior health care consultants, it ensures the highest level of health care and provides quality assurance. Most importantly, it ensures the maintenance of a readily mobile effective fighting force.

The entire waiver process normally starts at the local flight surgeon's office at the time of the discovery of a disqualifying medical condition. Local evaluations and consultations are performed and the crewmember's condition is carefully documented in an Aeromedical Summary (AMS). The AMS is explained in the following section. In addition to documenting the crewmember's work-up, the flight surgeon also documents his aeromedical disposition in the AMS. A recommendation on the medical disposition- qualified or disqualified- by the local flight surgeon is critical to the review process and must be clearly stated in the AMS. The AMS is forwarded to USAAMA where it can take several different routes depending on the nature of the disqualification.

Most waiver requests are routine waivers (those that have clear policy established) and require little more than review and endorsement. The packet is reviewed by the USAAMA physician staff that makes the final medical recommendation for the Commander, USAAMC. The packet will include an aeromedical disposition as well as any requirements for follow-up. Aeromedical disposition letters are reviewed and signed by the Director, USAAMA. The packet is then forwarded to the appropriate waiver authority for approval action. This is the quickest possible mechanism of action.



Occasionally, the USAAMA physician staff upon initial review may want a second opinion or additional consultation. This most commonly consists of a case / chart review. In these cases, they will forward the AMS to the appropriate Army aeromedical consultant, the Naval Aerospace Medical Institute (NAMI), Pensacola, FL, or the USAF Aerospace Medicine Consultation Service (AMCS), Brooks AFB, TX.

Cases that are unusual, potentially precedent setting, involve significant flight, or other operational limitations may be presented to the ACAP. The ACAP is a recommendation organization. The recommendation of the ACAP is reviewed and endorsed by the Commander, USAAMC and forwarded to the appropriate waiver authority. The waiver authority will then take appropriate action, normally producing a formal letter of waiver or a termination notification.

Waiver processing is time consuming. Complicated cases or cases that have no precedent often take additional time due to the need for specialty consultation or literature review. Remember, most routine waivers may be granted temporary clearance pending waiver and telephonic approval from USAAMA is available for the uncertain cases. If you need a rush disposition, you may send the waiver packet via overnight mail or Federal Express. Please ensure the package is complete. Fax copies are generally not accepted due to their poor quality and the ease with which they may be altered; however, they may be accepted through prior coordination with USAAMA staff.

Aeromedical Consultants Advisory Panel (ACAP)

Commander, USAAMC, appoints voting members to the ACAP. Generally, all aerospace medicine specialists assigned to Ft. Rucker are appointed as voting members. Additionally, experienced flight surgeons assigned to the various departments at Lyster Army Community Hospital are also appointed (e.g. ophthalmology, orthopedics, ENT, etc.). Additionally senior aviators are voting members of the ACAP and offer a “line” opinion on cases. The Director, AAMA chairs the ACAP and the Commander, USAAMC reviews the recommendations. The goal of the ACAP is to establish a consensus opinion of aeromedical experts for case review and disposition and for policy formulation.

Waiver Criteria

Factors commonly used in the consideration of granting a waiver include feasibility of treatment and follow-up requirements in a field/austere environment in addition to in-flight safety and mission completion. To be considered waiverable, any disqualifying physical or psychological defect is subjected to the following screening criteria:

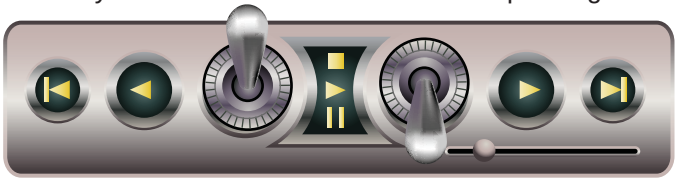
- The disqualifying defect must not pose a risk of sudden incapacitation.
- It must not pose any potential risk for subtle incapacitation that might not be detected by the individual but would affect alertness, special senses, or information processing.
- It must be resolved or stable at time of the waiver (i.e., non-progressive).
- It must not be subject to aggravation by military service or continued flying.
- It must not lead to significant loss of duty such as precludes satisfactory completion of training and/or military service.
- It cannot require the use of uncommonly available tests, regular invasive procedures, or non-routine medication especially during deployment or assignment to austere areas.
- If the possibility of progression or recurrence exists, the first signs or symptoms must be easily detectable and cannot constitute an undue hazard to the individual or to others.
- It cannot jeopardize the successful completion of a mission.

Sharing Information with Outside Agencies

USAAMA is required to pass to the Federal Aviation Administration the names of all aviators who are disqualified from flying duties in the US Army. Flight surgeons should brief patients who are facing likely disqualification accordingly.

Temporary Clearance Pending Waiver

Since getting formal action on a waiver request can take many months the flight surgeon may grant temporary clearance for minor disqualifications, when following established policy. For example, well-controlled hypertensives on a stable dosage of an approved anti-hypertensive agent are routinely granted waivers barring any other underlying medical conditions. This being the case, it is not necessary, to ground the aviator pending receipt of the waiver from the waiver authority. The flight surgeon may grant a temporary clearance pending waiver in the interim. This will



expedite the return to full duty for many aviators and will not compromise aviation safety and is in keeping with the spirit of applicable regulations. If you are unsure if granting a Temporary Clearance Pending Waiver is indicated in a particular case, call USAAMA and get a telephonic consultation.

Exceptions: The following conditions may NOT be granted temporary clearance pending waiver:

Alcoholism and substance abuse, arteriosclerotic vascular disease, myocardial infarction, cancer (except single episode of basal cell carcinoma), CVA and other significant CNS disorders (includes TIA, loss of consciousness when unexplained, seizure disorder), skull fracture or severe head injury, significant visual disturbance (e.g. uncorrectable to 20/20 or impaired depth perception).

Any aircrew that was previously medically disqualified and suspended from performing aviation duties who is seeking "requalification" should not be given temporary clearance.

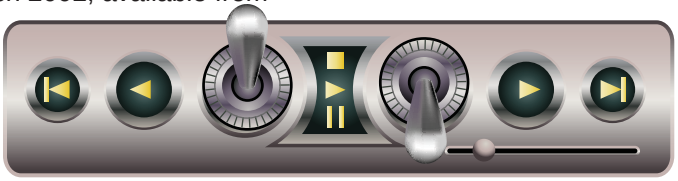
Aeromedical Summary: Guide to Completion

An Aeromedical Summary (AMS) is required for any action that requires waiver or permanent medical disqualification/suspension (permanent termination from flying). An abbreviated AMS may be used in certain minor actions, e.g., hearing loss, pregnancy, seasonal allergic rhinitis (SAR), hypertension controlled by diet or waiverable medications, and any other uncomplicated condition. Templates for both AMS formats are found in Appendix B. You will notice that the big difference is that the abbreviated AMS is more focused. The abbreviated AMS consolidates and abbreviates the occupational, aviation, social, family, and past medical history as well as the chief complaint and physical exam findings.

The AMS is preferably typed; however, handwritten submissions are acceptable but must be legible. Continuation sheets should be used as necessary. The AMS should be typed on Optional Form 275, Medical Record Report, March 2002, available from the U. S. Army Publishing Directorate website at: http://www.usapa.army.mil/. This will facilitate the incorporation of the AMS into Health Records. At a minimum, an original and a copy of the AMS and supporting documents must be made. The original is forwarded to USAAMA for processing. The copy of the AMS must be maintained on file in the FS's office for a minimum of 2 years IAW AR 40-501, paragraph 6-10 (c & d). Though not required, it is a good idea to make a second copy of the AMS and place it in the crewmembers HREC. This redundancy helps minimize problems with lost mail or PCSs of either the aircrew member or his flight surgeon.

It is encouraged to submit an FDME with the AMS but is not required. An AMS concludes with the FS's aeromedical recommendations. The local FS should make a simple declarative statement of what he believes will be best for the individual, flying safety, and the Army. The recommendations should focus on whether the individual is medically qualified and safe to fly. The FS should state the specific chapter/paragraph regulating the condition and any appropriate APLs. The FS must remain strictly objective and not allow his personal likes or dislikes, any outside pressure, or personal biases to influence his decision. His recommendation should include any restrictions as well as recommendations for follow-up or request for consultations that he feels are appropriate but not available at his location. USAAMA can coordinate further evaluation/consultation as necessary.

NOTE: Legibility is key. Altered (white out, erased, blocked out, etc.) records are not accepted.



Organization Of AMS Documents

In order to expedite processing of the aeromedical summary, it is important to place documents neatly labeled, tabulated and collated preferably in chronological order, earlier dates first. This will allow the reviewer to follow chronologically the development/resolution of the defect or condition. The documents should be assembled in the following order:

- Cover letter, if included.
- Aeromedical Summary.
- Enclosures:
  - Any available supportive consultations
  - Reports of all operations
  - Lab reports, pathology report, tissue examinations
  - Reports of all studies: x-rays, pictures, films, or procedures (ECG, AGXT, Holter, ECHO, cardiac scans, catheterization, endoscopic procedures, etc.)
  - Hospital summaries and past medical documents (e.g., hospital summaries); reports of any proceedings (tumor board, MEB, PEB, FEB)
- Letters of recommendation

NOTE: AMSs for civilian/contract personnel should indicate whether the individual is also in the Reserves or National Guard so that the waiver can be forwarded to all appropriate waiver authorities.

The Aeromedical Epidemiology Data Registry (AEDR)

This is a computer database maintained by the U.S. Army Aeromedical Activity containing extensive medical information concerning the physical and historical data related to Army aviators. This database often serves as the basis for the development of aeromedical policies and has enormous research potential. Requests for information should be directed through the Director, AAMA to Commander, USAAMC

Commander, USAAMC
ATTN: MCXY-AER
Ft. Rucker, AL 36362

Every time the FDME/FDHS is qualified by USAAMA, entries are made in the AERO on a cover sheet and history document. This document is returned with the original FDME/FDHS to the facility that generated the FDME/FDHS or is available electronically. The local FS and the crewmember should both review the verification sheet and submit changes electronically via the AERO/USAAMA help desk.

Review of the AMS / Waiver Process

The flight surgeon prepares an aeromedical summary (AMS). The AMS is submitted to USAAMA. USAAMA may refer the AMS to its Review and Disposition Service or Consult Service or to the Aeromedical Consultant Advisory Panel (ACAP).

The USAAMA Review and Disposition Service and Consult Service consists of physicians assigned to USAAMA. This service expedites routine cases (vision out of standards, but correctable, high frequency hearing loss, etc.) that have clear-cut answers.

Complicated cases are referred to the Aerospace Medicine Consultants and on occasion the Aeromedical Consultant's Advisory Panel (ACAP), which is composed of Aerospace Medicine Specialists, Clinical Medicine Specialists, and at least two Master/Senior Aviators. ACAP meets in formal session on a monthly basis and reviews complicated medical cases and formulates/recommends aeromedical policy.

USAAMA's waiver recommendation is forwarded from USAAMA to PERSCOM, NGB, or other waiver authority for final waiver approval or disapproval.

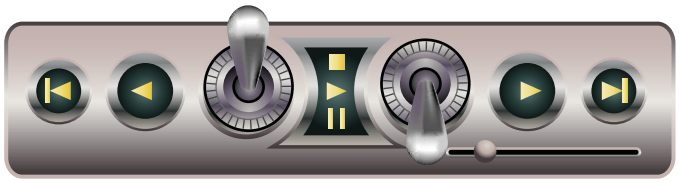


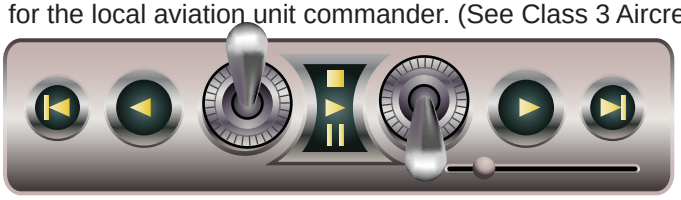
Table 7: Waiver Authorities

ACTIVE ARMY OR USAR **CLASSES I/IA AND CLASS 2** THRU Commander, USAAMC, ATTN: MCXY AER, Fort Rucker, AL 36362 5333 FOR Commander, PERSCOM, ATTN: TAPC PLA, 200 Stovall Street, Hoffman Building, Room 3N25 Alexandria, VA 22331 0413	**ACTIVE ARMY OR USAR** **CLASSES 2F & ETC*** THRU Commander, USAAMC, ATTN: MCXY AER, Fort Rucker, AL 36362 5333 FOR Commander, PERSCOM, Health 3 Services Division, ATTN: TAPC OPH MC, 200 Stovall Street Hoffman Building. Room 9N68, Alexandria, VA 22331 0413	**ACTIVE ARMY OR USAR** **CLASSES 2S/4 &CLASS 3 (FOR DRUG ALCOHOL ONLY)**** THRU Commander, USAAMC, ATTN: MCXY AER, Fort Rucker, AL 36362 5333 FOR Commander, PERSCOM, ATTN: TAPC EPL T 2461 Eisenhower Ave Alexandria, VA 22331 0453
ARNG **CLASSES 1 1/1A/2 //2F /2S /4, AND CLASS 3 (DRUG AND ALCOHOL ONLY)**** THRU Commander, USAAMC, ATTN: MCXY AER, Fort Rucker, AL 36362 5333 FOR Chief, National Guard Bureau, ATTN: NOB AVN OP 111 South George Mason Drive, Arlington VA 22204 1392	**Contract Civilians** **All CLASSES** THRU Commander, USAAMC, ATTN: MCKY AER, Fort Rucker, AL 36362 5333 THRU Contracting Representative Officer FOR Commanding General, or his Designated Waiver Authority (i.e., air field commander or command aviation officer). Send final copy to Contracting Office & Firm.	**DAC** **ALL CLASSES** THRU Commander, USAAMC, ATTN: MCXY AER, Fort Rucker, AL 36362 5333 THRU Aviation Unit Commander FOR Commanding General, or his designated waiver authority (airfield commander or command aviation officer). Send final copy to local civilian personnel office.

* Includes aviation audiologists, dentists, optometrists, and psychologists.

**Class 3: Several other conditions require submission to USAAMA for final review and disposition to include:

- Alcohol and Drug abuse or dependence as above.
- Type II decompression sickness.
- Coronary disease, suspected or proven.
- HIV seropositivity. (Civilian employees are not disqualified based solely on the presence of the HIV virus)Any other condition for which the FS or local aviation commander requests consultation.
- Waivers for other than drug and alcohol abuse/dependence and the above conditions are submitted through the local FS, for the local aviation unit commander. (See Class 3 Aircrew Members AP)



Flight Duty Medical Exam (FDME) Checklist

Version: 4 Mar 06

**Note: Comprehensive FDME q5 yrs between ages 20-50; then annually (based on date of last FDME)*

°Note: Flight Duty Health Screen (FDHS) requires physical exam only as indicated

Aeromedical Standards

Initial	Comp*	FDHS°		ALL Standards Qualified if:		See DD2808 Block #:
☑ Check in & Vital Signs						
■	■	4497	DD 2807, DD 2808 (DD 2697 Retirement Physicals)			1-30
■	■	■	Sitting BP, Pulse, (Temperature)	Pulse ≥50 and ≤100 BP <140/90		56-58
■	■	■	(Height, Weight)	*See AR 600-9*		53-54
■			Anthropometrics (1A/1W Only)	Crotch Ht (CH) ≥75cm Total Arm Reach (TAR)≥164cm Sitting Ht (SH) ≤102cm (≤95cm for OH-58)		73
☑ Vision				*Class 1/1A*	*Class 2/3/4*	
■	■	■	Distant Visual Acuity *By projected chart only*	20/50	20/400	61
■	■	■	Near Visual Acuity	20/20	20/400	63
■	■	■	Refraction: Manifest/Subjective (Lens Rx if corrected to 20/20-1)	Not Required	Must correct to 20/20-1	
■			Refraction: Cycloplegic (1A/1W only) Annotate cycloplegic protocol *1gtt proparicaine 0.5% ➲ 1gtt cyclopentolate 1.0% @1 min and 6min*	-1.50 ⇔ +3.00 S. Must -1.00 ⇔ +1.00 Cx. Transpose	Not Required	62
■	■	■	Stereopsis (Randot, Titmus, or AFVT)	≤40° arc @20'(No Errors on Titmus 0/9,Randot:lines 1-7/10, AFVT:grp B)		67
■	■		Phorias by AFVTA	≤8 Eso; ≤8 Exo; ≤1 Hyper		64
■			Cover-uncover test (tropias)	No detectable movement (ORTHO)		64
■			Near Point Convergence (NPC)	≤100mm		64
■	⊙	⊙	IOPs	≥7 and ≤21mmHg; <4mmHg Δ between eyes		70
■			Color vision (PIP or Falant only)	PIP: ≤4/14 Falant: 0/9		66
■			Visual fields (confrontation)	NTC or FTC OU		68
■			Night Vision Hx	NIBH		69
☑ Audiogram				*Class 1/1A*	*Class 2/3/4*	
■	■	■	500 -2000Hz	≤25 dB (no shift > 20 in any freq)		71
■	■	■	3000 Hz	≤35 dB		
■	■	■	4000 Hz	≤45 dB	≤55 dB	
■	■	■	6000 Hz	≤45 dB	≤65 dB	
☑ (Dental)			(annual readiness requirement IAW AR 40-3)	*Class I or II*		
☑ ECG			(Initial and over 40)	*See APL*		
☑ Laboratory				*Male*	*Female*	
■	■		UA w/Micro; Report (Spec Gravity), Glu, Pro, RBC, WBC	Glu Neg ; Pro Neg ; ≤4 RBC ;≤4 WBC		45,73
■	■		HCT or Hb	40-52% (14-18 gm/dl)	37-47% (12-16gm/dl)	47
■	■		HIV (annotate date drawn) (optional for DAC)	Performed every 2 yrs		49
■	⊙	⊙	Fasting Glucose	≤109 (see DM APL)		73
■	■	⊙	Lipid Panel (chol, HDL, LDL, Trig, Chol:HDL ratio)	*See APL*		73
■			Sickledex (except Class 4)	Negative		73
⊙	⊙		PSA (males)			73
⊙	⊙		Stool Guiac	Negative		30
⊙	⊙	⊙	Cardiac Risk Index (AERO)	*<7.5 (see CV Screening APL)*		73
☑ Radiology						
			CXR ➲ Sere, SF, MFF, Dive, Retirement (>40) Physicals only			73
⊙	⊙	⊙	(Mammogram (Females)) ➲ Age 40,42,44,46,48,50, then yearly			73
☑ Flight Surgeon's Evaluation						
■	■		Physical Exam			17-44
	■	■	PAP Test & pelvic (Chlamydia req for Female <25y/o)			18,52
■	■	■	AR 40-8 Statement			29
■			Reading aloud Test	Satisfactory (Clear, deliberate; without hesitation, error, stuttering)		72a
■			Aeronautical Adaptability (AA)	Satisfactory		40
■			Valsalva (except Class 4)	TM's Mobile		21,72b
⊙	⊙		DRE(+Prostate)			30
■			Contact Lens or Refractive surgery	See Corresponding APLs		
(■)			SF, MFF, Dive ➲ G6PD, WBC, CXR			73
(■)			Pre-commissioning/induction ➲ Pregnancy Test, Urine Drug/EtOH Screen			46-51
			Retirement ➲ Comprehensive exam + CXR (>40), DD FORM 2697, Counseling re: HCV			73

⊙ = 40 and over

■ = Required

( ) = Recommended or req by AR 40-501, readiness requirements, or other physicals

Additional tests, studies and consults needed:

☎Home: DOB: Today's Date:

☎Work: Age: Date of last Comprehensive FDME:

Name / Rank	Provider's Stamp	Status
SSN / Unit		

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